

KENTUCKY
OFFICE OF WORKERS' CLAIMS
Application for Resolution of Injury Claim
Claim No. _____

..... Plaintiff Social Security Number Birth Date Street Address City/State/Zip Code County Phone Number	vs. Defendant/Employer Street Address City/State/Zip Code Insurance Carrier Street Address City/State/Zip Code Defendant Other Defendant Street Address City/State/Zip Code Reason for Joinder: Other Defendant Street Address City/State/Zip Code Reason for Joinder:
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Filed:

I. Nature of Injury

1. Plaintiff states that on the _____ day of _____ 20____, he/she was injured within the scope and course of employment with defendant employer at _____

(City/County/State)

2. Describe how the injury occurred: _____

3. Body part injured: _____
4. State the date and means by which the plaintiff gave notice of injury to the employer:

5. Describe medical treatment, if any: _____

6. Name and address of physician whose report is attached: _____

II. Personal Data

7. Name and address of last school attended: _____

8. Highest grade completed in school: _____
9. GED awarded: ____ yes ____ no
10. Professional or vocational degrees, certificates, or licenses: _____

11. Dependents:	Name	Date of Birth	Social Security Number	Relationship

12. Have you previously filed for or received workers' compensation benefits? ____yes ____no

If yes, give Office of Workers' Claims file number(s), dates and nature of injury or disease and any award of benefits received; _____

III. Employment Data

13. Is plaintiff currently working? _____ yes _____ no
14. Type of work performed at date of injury: _____

15. Describe the physical requirements of job performed at date of injury: _____

16. Weekly wage at date of injury: _____. Attach copy of any proof of wages, such as paycheck stub, W-2, etc.
17. Weekly wage currently earned:_____ Attach copy of any proof of current wages.
18. Name and address of current employer and description of job currently being performed: _____

19. Are you alleging a violation of a safety rule/regulation pursuant to KRS 342.165?
yes_____ no_____

Notice: Any person who knowingly and with intent to defraud any insurance company or other person files a statement or claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Plaintiff herein being duly sworn, states that the statements in this application and in Form 104, 105, and 106 are true. This the _____ day of _____ 20____.

Plaintiff's Signature

Subscribed and sworn to before me this _____ day of _____ 20____.

Notary Public

My Commission expires: _____ County: _____

Prepared and submitted by:

Signature/Representative for Plaintiff

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le

Street Address

City/State/Zip

Telephone Number

Instructions for Completion of Forms 101, 102 and 103

Form 101 - Application for Resolution of Injury Claim

1. All sections of this form must be completed, and must be accompanied by the following:
 - a. Form 104 (Plaintiff's Employment History)
 - b. Form 105 (Plaintiff's Chronological Medical History)
 - c. Form 106 (Medical Waiver and Consent)
 - d. Medical report describing and supporting the injury which is the basis of the claim.
 - e. Proof of Wages, including W-2's, paycheck stubs, etc.
2. All information must be typewritten.
3. File the original of this form and sufficient copies for all named defendants with the **Office of Workers' Claims**, Prevention Park, 657 Chamberlin Avenue, Frankfort, Kentucky, 40601.
4. If you have no telephone number, please list a number at which you may be contacted.
5. If you have questions, call 1-800-554-8601

Form 102 - Application for Resolution of Occupational Disease Claim, and Form 103 - Application for Resolution of Hearing Loss Claim

1. All sections of this form must be completed, and must be accompanied by the following:
 - a. Form 104 (Plaintiff's Employment History)
 - b. Form 105 (Plaintiff's Chronological Medical History)
 - c. Form 106 (Medical Waiver and Consent)
 - d. Medical report supporting the occupational disease
 - e. Proof of Wages, including W-2's, paycheck stubs, etc.
 - f. Social Security earnings record release form.
2. This form may be filed in combination with an Application for Resolution of Injury Claim (Form 101) if both benefits are sought. Information provided should be current through the date application is signed by plaintiff.
3. All information must be typewritten.

4. File the original of this form and sufficient copies for all named defendants with the **Office of Workers' Claims**, Prevention Park, 657 Chamberlin Avenue, Frankfort, Kentucky, 40601.
5. If you have questions, call 1-800-554-8601

Note: Special attention should be given to stating the correct name and address of the employer and insurance carrier. Otherwise, claim processing may be delayed.

Revised ~~January 25, 2005~~